

TERMS AND CONDITIONS

By signing the front of this election form, I understand that:

The dependent day care expenses and out-of-pocket medical expenses that qualify under Section 125 of the Internal Revenue Code are separate flexible benefit accounts. My contributions to and expenses incurred for each flexible benefit account are separate and non-transferable from one account to another.

I will be reimbursed for out-of-pocket medical expenses at any point during the Plan Year up to the amount of my Plan Year Election. Dependent day care expenses will not be reimbursed in excess of the amount in my flex account, unless otherwise specified by my employer.

In order to change my election after the Plan Year has begun, I must experience a qualified Change in Status Event. Election changes due to a Change in Status Event must be made within 60 days after the event unless otherwise specified in my Summary Plan Description AND must be consistent with the change that took place as defined by the IRS Consistency Rule. The effective date of the election brought forth by the Change in Status Event is the later of the: (1) date of the Change in Status Event, or (2) the date you requested the change, except for the birth or adoption of a child where HIPAA special enrollment rules apply. The following chart outlines the qualifying Change in Status Events:

Events for employer-sponsored health-related and group term life insurance plans and the out-of-pocket medical expense account
Change in Status – Qualifying Events
1. Change in legal marital status – Marriage, divorce, death of spouse, legal separation, and annulment. 2. Change in the number of tax dependents – Birth, adoption, placement for adoption, and death of a dependent. 3. Change in employment status of the employee, employee's spouse or employee's dependent(s) – Termination or commencement of employment, strike or lockout, commencement of, or return from an unpaid leave of absence, a switch between part-time and full-time employment, or a change in worksite. 4. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements – Due to attainment of limiting age under the insurance plan, gain or loss of student status, marriage or any similar circumstance. 5. Residence change of the employee, employee's spouse, or employee's dependent(s) – Only allowable if the change in residence affects the employee's eligibility for coverage.
Consistency Rule
In order to change your election, the change must be on account of and correspond with a Change in Status Event that affects you, your spouse or your dependent's eligibility for the employer-sponsored benefit plan(s). In other words, the increase or decrease in your flexible benefit plan election amount must be consistent with the gain or loss of your eligibility to participate. If the Change in Status Event does not affect the eligibility of that insurance and/or out-of-pocket medical expense you cannot make the change. Special consistency rules also apply for the following situations: loss of dependent eligibility, gain of coverage eligibility under another employer's plan, and life or disability coverages. Should you need clarification of these events, please call ProcessWorks.
Additional Change in Status – Qualifying Events
Cost changes with automatic election increases/decreases,* significant cost increases,* significant coverage curtailment,* addition or elimination of benefit package options offered by your employer,* change in coverage of spouse or dependent under another employer's plan,* Family Medical Leave of absences as qualified under FMLA, HIPAA special enrollment rights, qualification and election under COBRA or state continuation,* Medicare or Medicaid entitlement or curtailment, or a judgment, decree or court order including a Qualified Medical Child Support Order.
* Does not apply to the out-of-pocket medical expense account.
Events for Dependent Day Care Account
Marriage, divorce, death, birth or adoption of a child of the employee, termination or commencement of employment of the employee's spouse, a switch between full-time and part-time by the employee or employee's spouse, taking an unpaid leave of absence or returning from an unpaid leave by the employee or employee's spouse, going on or returning from a Family Medical Leave of absence as qualified under FMLA.

The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it believes the reduction or cancellation is advisable in order to satisfy certain provisions of the Internal Revenue Code. Prior to each Plan Year I will be given the opportunity to change my Flexible Benefit Plan Election for the upcoming Plan Year.

My Social Security benefits may be affected because I am lowering my taxable income by electing to participate in the Flexible Benefit Plan. This means that my Social Security benefits could be decreased because of the decreased amount of compensation which is considered for Social Security purposes. In most cases, my Flexible Benefit Plan election will not affect any other benefits I receive from my Employer. However, paying for disability income policies pre-tax will cause the benefits payable there under to be taxable.

To receive these tax-free benefits, I must plan ahead. Planning is important because the IRS says that I will lose any unused money in my flex accounts at the end of the Plan Year. These tax-free dollars can only be used for eligible dependent day care and out-of-pocket medical expenses that were incurred (not paid or billed) during the same Plan Year in which I set aside the money for. All claims must be submitted by the end of the Plan Year filing period. Any claims submitted after that time cannot be considered. Any monies forfeited may not be paid back to me in any manner or used to provide future benefits, according to IRS regulations.



City of Memphis Benefits Department
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Flex Benefit Plan Enrollment/Change Form

Directions:

Employee - Complete Sections 1, 2 and 3

Employer - Complete 'Change Type' Box to the right and complete Section 4

Please call UnitedHealthcare Benefit Services if you have any questions

Change Type: Date of event ____/____/____
(Section 4 below must be completed)

- ☐ Address/Name change
☐ New Hire
☐ Termination (must complete COBRA form*)
☐ Change in Status _____
☐ Unpaid Leave of Absence
☐ Return from Leave of Absence

*For out-of-Pocket Medical Expense account participants

1 Employee Information

Social Security Number ____	Email Address _____	Plan Year: From ____/____/____ To ____/____/____ Effective Date: ____/____/____ (New Employees Only)
Employer Name (Last name, First name, Middle Initial)		
Employee Address (Street, Apt #)		
Employee Address (City, State, Zip Code)		
Employer Name City of Memphis Government		

2 Flex Benefit Election

- ☐ I hereby elect to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with before-tax dollars. I hereby authorize my Employer to reduce my income subject to taxes in the total amount stated below for the above Plan Year. If my group insurance requires a change in my contribution during the Plan Year I authorize my Employer to make the contribution adjustments.

I. Dependent Day Care Expenses \$ _____ ÷ 24 = \$ _____
(Calendar year limit of \$5000 per family OR
\$2500 if married and file separate tax returns) Plan year Election Amt No. of Paychecks Amount Per Paycheck

II. Out-of-Pocket Expenses \$ _____ ÷ 24 = \$ _____
(Expenses for Medical, Dental, Vision, etc.) Plan year Election Amt No. of Paychecks Amount Per Paycheck

Do you or any of your family members participate in a Health Savings Account (HSA)? ☐ Yes ☐ No
(If yes, an out-of-pocket medical expense FSA is not available.)

- ☐ I hereby elect NOT to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with after-tax dollars. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent Plan year, in accordance with the procedures described in the Plan Document.

3 Signature and Acknowledgement - The back of this form must be read before signing

This agreement will remain in effect for the Plan year unless changed for reasons stated in the terms and conditions of the Plan on the back of this form. By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the qualifying event. I agree to hold UnitedHealthcare Benefit Services and my employer harmless from any liability to my participation in this plan.

Employee Signature _____ Date ____/____/____

4 Employer's Use Only

Category	First Payroll Date	Last Payroll Date	YTD Deductions	\$ _____ (Dental)	\$ _____ (Life)	\$ _____ (Other)
Group Ins.	____/____/____	____/____/____	\$ _____ (Health)			
Day Care	____/____/____	____/____/____	\$ _____			
Medical	____/____/____	____/____/____	\$ _____			
Private Ins.	____/____/____	____/____/____	\$ _____			
Authorized Signature _____			Date ____/____/____			

First Payroll Date applies if making a new election. Last Payroll Date and YTD Deductions apply if changing an old election or termination.